



The Health of New Hampshire's Community Hospital System

A Financial Analysis

Valley Regional Hospital



Office of Planning and Research
New Hampshire Department of Health and Human Services
129 Pleasant Street • Concord, New Hampshire 03301
www.dhhs.state.nh.us

An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

February 2001

Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS ¹	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

¹ Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses) ²
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

² (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire*.

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with \$100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

Acknowledgements

The Department wishes to thank the following individuals and organizations for making this financial analysis possible. First, this project was made possible through a grant from The Robert Wood Johnson Foundation's *Access Project*, directed by Catherine Dunham, Ed.D. Second, Dr. Nancy Kane and her graduate students at the Harvard School of Public Health prepared the financial analysis and narratives. Finally, the Department extends its appreciation to the Chief Financial Officers and Presidents of each New Hampshire hospital for reviewing the standardized financial spreadsheets and financial analysis to ensure their accuracy.

For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

VALLEY REGIONAL HOSPITAL CLAREMONT, NEW HAMPSHIRE 1993 – 1999 FINANCIAL ANALYSIS

Valley Regional Hospital in Sullivan County is a small acute-care facility with 43 beds.³ As of 1997, Medicare followed by private insurers represented the largest percentage of payers for inpatient discharges (37 and 36%, respectively)⁴.

Valley Regional Healthcare, Inc., is the nonprofit (NP) parent holding company of the hospital. In addition to the hospital, other subsidiaries include Valley Regional Ventures, Inc. a pharmacy management service, and Valley Regional Real Estate. The tax status of these subsidiaries was not disclosed.

In 1995, the parent transferred the operations of River Valley Associates, a medical practice, to the hospital. Additionally, in 1997, the hospital merged with Connecticut Valley Homecare, Inc. (NP), which had previously been a wholly-owned subsidiary of the parent.

Summary of Financial Analysis 1993-98

Financial performance was weak over this six-year period. The hospital could not produce positive profit margins in four of the last seven years. We were unable to separate operating from non-operating profits since 1993. Poor profitability prevented the hospital from building stronger liquidity and led to a recent decline in solvency.

Cash Flow Analysis 1993-98

The hospital relied mostly on depreciation to generate cash (71% of total sources), while net income provided only 17% of the total cash due to low margins. Debt sources of capital supplemented these internal sources and represented an additional 8% of the total cash after outstanding debt was turned over.

Investment in property, plant and equipment (PP&E) required over half the cash during the period. This amount of investment (\$5.2M) was 28% below depreciation expense (\$7.2M), and may not have been adequate given the steady increase after 1994 in the average age of plant, which reached 11.7 years by 1998.

One fifth of the cash was used to invest in marketable securities, which allowed the hospital to maintain just over 100 days cash on hand, including board-designated investments.

Net working capital required 13% of cash, mainly due to growth in accounts receivable. Collections slowed over the period from 54 days to 74 days. Affiliate transactions – loans and equity transfers – represented a net outflow of cash for the hospital, absorbing 9% of its cash.

³ The 1998 American Hospital Association Guide.

⁴ 1997 data from the State of New Hampshire Department of Health and Human Services.

Ratio Analysis 1993-98⁵

Profitability

Profitability was weak as the hospital either broke even or experienced a loss in recent years. Profits have been low since 1995, the year the hospital assumed operations from the medical practice.

Despite fairly strong 6% margins in 1994, profitability declined and the hospital broke even the following year, with low profitability persisting through 1998, ranging from break even to margins of -1%. The years in which the hospital was able to generate positive margins (6% in 1994 and 2% in 1997) followed growth in the markup of charges over cost that offset payer deductions (deductible). After 1994, it appeared that the hospital could not collect its markup from third party-payers and self-pay patients, which led to the erosion of the margin.

The hospital may have experienced even larger operating losses than what is shown by this analysis due to its accounting practice of reporting nonoperating revenues with operating revenues. We, therefore, cannot determine what the true operating losses were.

Liquidity

The hospital's current ratio remains above 2 in recent years, though its management of working capital is poor. The current ratio demonstrates that the hospital can meet its current obligations, but this measure is largely driven by the growth in accounts receivable resulting from slowed collections over the period – from 56 to 74 days. Growth in 1998 may have been partly due to the merger with the homecare company.

Despite marked improvement in current cash resources after 1993, the days cash on hand with short-term sources measure declined after 1996. By 1998, the hospital had 27 days cash. Growth in days cash with all sources – from 72 to 101 days – reflects the hospital's conversion of cash into marketable securities.

Payments to vendors were managed well as illustrated by the trend in average pay period, which remained unchanged over the period at about 26 days.

Capital Structure

Valley Regional carries a fairly high level of long-term debt (equity financing in the 40-43% range) for a small hospital. This level of financial risk placed the hospital in the highest 10th percentile in the state in terms of financial risk in 1997. By 1998, it appears that shrinking equity due to operating losses in recent years negatively affected the capital structure, as the equity financing ratio fell between 1997 and 1998 despite no new debt issuance.

Indicators of debt coverage further reflect the impact of poor profitability on the hospital's solvency. The cash flow to total debt measure was low relative to the state median in 1997, and was erratic following fluctuating profitability. Debt service indicators demonstrate that the hospital can meet its debt principal and interest payments, though again, the fluctuations in this trend are not a good sign. Meanwhile plant age increase by 2.8 years over the period, making it one of the older hospitals (11.6 years) in the state by 1998.

⁵ NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

Charity Care and Community Benefits

Charity care reported as charges forgone ranged from 2-2.6% of gross patient service revenues over the period 1993 to 1998. This amount of charity care met the estimated value of the hospital's tax exemption in all years with the exception of 1994, the hospital's most profitable year. In this year, the hospital met its estimated tax value benchmark with the inclusion of 50% bad debt.

The hospital reported additional community benefits as Medicaid costs exceeding payment (\$4M) and community service programs (\$1.9M). Medicaid costs exceeding payment are not allowable under the New Hampshire community benefit statute. With the addition of these amounts to free care, the hospital met its estimated tax liability in 1994.

Valley Regional Hospital also operates a trauma center¹, which could be considered an additional charitable benefit to the community.

Cash Flow Analysis 1993 - 1999

The hospital relied mostly on depreciation to generate cash - 62% of total sources - while net income provided only 17% of the total cash, due to low margins.

Investment in property, plant, and equipment (PP&E) required over half (52%) of the cash during the period. The \$7.2 million PP&E investment was 15% below the \$8.6 billion depreciation expense. This may not have been adequate, given the steady increase after 1994 in the average age of the plant. By 1999, the average age of plant reached 11.3 years.

18% of the cash was used to invest in marketable securities, which allowed the hospital to maintain just over 110 days cash on hand, including board-designated investments.

The net working capital required 18% of cash, mainly due to growth in accounts receivable. Collections have slowed during the year from 74 days in 1998 to 82 days in 1999. Affiliate transactions - loans and equity transfers - represented a net outflow of cash for the hospital, absorbing 6% of its cash.

1999 Ratio Analysis

Profitability

The operating margin improved from 0% to 3%. This is mainly due to an increase in the total operating revenue by 6% and related expenses increasing by only 4%. The mark-up also increased from 1.43 times to 1.53 times, while the deductible increased from 26% to 29% of gross revenue.

Liquidity

The hospital's current ratio remains above 2 in 1999. The current ratio demonstrates that the hospital can meet its current obligations, but this measure is largely driven by the growth in accounts receivable, which resulted from slowed collections over the period - from 74 to 82 days. The 82 days of accounts receivable was at the 75th percentile of New Hampshire and above the 1997 regional and national average of 60.5 days and 28 days.

In 1999, the hospital had 26 days current cash, a decrease of one day from 1998. Growth in days' cash with all sources - from 101 to 110 days - reflects the hospital's conversion of cash into board-designated securities.

The payment cycle to vendors decreased from 26 days to 21 days in 1999. This decrease in days of payment to vendor, in conjunction with the slow collection of accounts receivable, contributed to the decline in the hospital's current cash position from 62.93 days in 1994 to the 26.07 days in 1999.

Capital Structure

Valley Regional Hospital carries a fairly high level of long-term debt (equity financing in the 40% to 44% range). The level of financial risk placed this small hospital in the highest 10th percentile of the state in terms of financial risk.

The debt service coverage ratio is 3.23. It has improved over 1998, due to improvement in the operating margin. The average plant age in 1999 was 11.35 years.

Charity Care and Community Benefits

Charity care reported as charges forgone was 1.34% of gross patient service revenues in 1999. The total bad debt reflected 4.51% of the gross patient service revenue. The hospital did not report any additional community benefits in the footnote to its financial statement.

Summary

The 1999 hospital performance is an improvement over 1998, but it still has a number of potential problems. In particular, the accounts receivable days increased significantly, and the bad debt provision also increased from 3.59% in 1993 to 4.51% in 1999. The hospital also has a high level of debt for such a small hospital, with slightly less cash than long-term debt on the balance sheet. Finally, plant age remains old despite absorbing 52% of all cash sources 1993-99.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health